Announced Post-Registration Medicines Management Inspection Report
14 March 2018

Trinity House

Type of service: Residential Care Home
Address: 15 Kilrea Road, Coleraine, BT51 5LP
Tel No: 028 2954 8128
Inspector: Rachel Lloyd

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a residential care home registered to provide care for up to 50 residents as detailed in section 3.0

3.0 Service details

Organisation/Registered Provider: Presbyterian Council of Social Witness **Responsible Individual:** Mrs Linda May Wray	**Registered Manager:** See below
Person in charge at the time of inspection: Mrs Jayne Bellingham	**Date manager registered:** Mrs Jayne Bellingham - registration pending.
Categories of care: Residential Care (RC): I – Old age not falling within any other category DE – Dementia	**Number of registered places:** 50 comprising: A maximum of 36 residents in category RC-I and a maximum of 14 residents in category in category RC-DE.

4.0 Inspection summary

An announced inspection took place on 14 March 2018 from 10.40 to 14.25.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

This was the first medicines management inspection since registration. The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to medicines administration, most of the medicine records, medicine storage and the management of controlled drugs.

One area for improvement was identified in relation to ensuring that all personal medication records and any new entries are verified and signed by two trained and competent members of staff.

Comments from the resident spoken to and observation of the environment throughout the home and the interactions between staff and residents were all very positive.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and residents experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Jayne Bellingham, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection

No further actions were required to be taken following the unannounced post-registration inspection on 3 January 2018. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following:

- recent care inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related incidents - it was ascertained that no incidents involving medicines had been reported to RQIA since the home registered.

A poster informing visitors to the home that an inspection was being conducted was displayed.

During the inspection the inspector met with one resident, two senior care assistants and the manager.

Ten questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

A sample of the following records was examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicines storage temperatures

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 3 January 2018

The most recent inspection of the home was an unannounced post-registration care inspection. There were no areas for improvement identified as a result of the inspection.

6.2 Review of areas for improvement from the last medicines management inspection

This was the first medicines management inspection since the registration of the home in October 2017.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Medicines were managed by staff who have been trained and deemed competent to do so. An induction process was in place for care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings and supervision. The manager stated that annual appraisal and competency assessment will take place. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

The systems in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage were examined. Some overstock of medicines prescribed for use “when required” was observed. Staff and management were advised of the Health and Social Care Board guidelines for the management of prescription ordering by registered care homes. Systems should ensure that medicines are not ordered unless required. The manager agreed to review this and ensure that no further supplies of these medicines are ordered until needed. Staff advised of the procedures to identify and report any potential shortfalls in medicines. Antibiotics and newly prescribed medicines had been received into the home without delay.

The arrangements in place to manage changes to prescribed medicines were largely satisfactory. However, all personal medication records and any new entries should be verified and signed and dated by two trained and competent members of staff to ensure accuracy in transcription. An area for improvement was identified.

There were procedures in place to ensure the safe management of medicines during a resident’s admission to the home and discharge from the home.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Checks were performed on controlled drugs which require safe custody, at the end of each shift. Additional checks were also performed on other controlled drugs which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

The arrangements for administering medicines in disguised form where necessary were examined. Staff were advised to include this in the residents' care plan, including who was involved in the decision making. This was addressed immediately.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. Medicine refrigerators and oxygen equipment were checked at regular intervals.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, the management of medicines on admission, the management of controlled drugs and the storage of medicines.

Areas for improvement

All personal medication records and any new entries should be verified and signed and dated by two trained members of staff to ensure accuracy in transcription.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome

The sample of medicines examined had been administered in accordance with the prescriber's instructions. There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of weekly, monthly or three monthly medicines were due.

When a resident was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the dosage instructions were recorded on the personal medication record. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a resident's behaviour and were aware that this change may be associated with pain. The reason for and the outcome of administration were recorded.

The manager agreed to ensure a care plan was put into place following the inspection for one resident and to ensure it reflected the circumstances when the medicine was to be administered.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable. Staff advised that most of the residents could verbalise any pain, and a pain assessment tool was used as needed. A care plan was maintained.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the resident's health were reported to the prescriber.

Medicine records were well maintained and readily facilitated the audit process. Areas of good practice were acknowledged. These included documenting the date of opening of medicines. For some residents a second personal medication record and medication administration record were in use. Staff were reminded that these must be marked 1 of 2, 2 of 2 etc.

Practices for the management of medicines were audited throughout the month by the staff and management. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to the needs of the residents.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the standard of record keeping and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The administration of medicines to residents was completed in a caring manner, residents were given time to take their medicines and medicines were administered as discreetly as possible.

Throughout the inspection, good relationships were observed between the staff and the residents. Staff were noted to be friendly and courteous.

Residents who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.
The resident spoken to was complimentary about the management of their medicines, the care received and the staff and management.

Ten questionnaires were left in the home to facilitate feedback from residents and relatives. One was returned within the specified timescale (two weeks). The responses indicated that the respondent was very satisfied with all aspects of the care in relation to the management of medicines. They commented that there had been "an excellent start for Trinity House".

Any comments from residents, their representatives or staff in questionnaires received after the issue of this report will be shared with the manager for their information and action as required.

Areas of good practice

There was evidence that staff listened to residents and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

Written policies and procedures for the management of medicines were in place. Following discussion with staff it was evident that they were familiar with these.

There were arrangements in place for the management of any medicine related incidents. Staff confirmed that they knew how to identify and report incidents. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding lead and safeguarding team.

A review of the audit records indicated that satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion and observation, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with management. They stated that there were good working relationships.

No members of staff shared their views by completing the online questionnaire prior to the issue of this report.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Mrs Jayne Bellingham, Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the residential care home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)

Area for improvement 1 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 13 April 2018	The registered person shall ensure that all personal medication records and any new entries are verified and signed and dated by two trained and competent members of staff to ensure accuracy in transcription. Ref: 6.4
	Response by registered person detailing the actions taken: Senior staff have been advised to sign and date and random checks by the Home Manager will be undertaken to ensure compliance.

Please ensure this document is completed in full and returned via the Web Portal

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